

116TH CONGRESS
2D SESSION

S. 5000

To provide support with respect to the prevention of, treatment for, and recovery from, substance use disorder.

IN THE SENATE OF THE UNITED STATES

DECEMBER 10, 2020

Mr. PORTMAN (for himself, Mr. WHITEHOUSE, Ms. KLOBUCHAR, Ms. CANTWELL, and Mrs. SHAHEEN) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

A BILL

To provide support with respect to the prevention of, treatment for, and recovery from, substance use disorder.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “CARA 2.0 Act of 2020”.

6 (b) TABLE OF CONTENTS.—The table of contents for
7 this Act is as follows:

Sec. 1. Short title; table of contents.
Sec. 2. Findings.

TITLE I—RESEARCH, EDUCATION, AND PREVENTION

- Sec. 101. National Education Campaign.
- Sec. 102. Research into non-opioid pain management.
- Sec. 103. Long-term treatment outcomes research.
- Sec. 104. National Commission for Excellence on Post-Overdose Response.
- Sec. 105. Workforce for prevention.
- Sec. 106. Reauthorization of community-based coalition enhancement grants to address local drug crises.

TITLE II—TREATMENT

- Sec. 201. Three-day limit on opioid prescriptions.
- Sec. 202. Evidence-based substance use disorder treatment and intervention demonstrations.
- Sec. 203. National youth and young adult recovery initiative.
- Sec. 204. Improving treatment for pregnant, postpartum, and parenting women.
- Sec. 205. Require the use of prescription drug monitoring programs.
- Sec. 206. Prescriber education.
- Sec. 207. Prohibition of utilization control policies or procedures for medication-assisted treatment under Medicaid.
- Sec. 208. Pilot program on expanding access to treatment.
- Sec. 209. Reauthorization of PRAC Ed grant program.

TITLE III—RECOVERY

Subtitle A—General Provisions

- Sec. 301. Building communities of recovery.
- Sec. 302. Medication-assisted treatment for recovery from substance use disorder.
- Sec. 303. Recovery in the workplace.
- Sec. 304. Telehealth for recovery support services.

Subtitle B—Recovery Housing

- Sec. 311. Clarifying the role of SAMHSA in promoting the availability of high-quality recovery housing.
- Sec. 312. Developing guidelines for States to promote the availability of high-quality recovery housing.
- Sec. 313. Coordination of Federal activities to promote the availability of high-quality recovery housing.
- Sec. 314. NAS study.
- Sec. 315. Grants for States to promote the availability of high quality recovery housing.
- Sec. 316. Authorization of appropriations.
- Sec. 317. Reputable providers and analysts of recovery housing services definition.
- Sec. 318. Technical correction.

TITLE IV—CRIMINAL JUSTICE

- Sec. 401. Medication-assisted Treatment Corrections and Community Reentry Program.
- Sec. 402. Deflection and pre-arrest diversion.
- Sec. 403. Housing.
- Sec. 404. Veterans treatment courts.

1 **SEC. 2. FINDINGS.**

2 Congress finds as follows:

3 (1) In the 1980s and 1990s, pharmaceutical
4 companies began developing new drugs for pain
5 treatment, including extended release oxycodone.
6 These companies aggressively marketed these drugs
7 to the medical community as a way to address
8 “under-treatment” of physical pain. Drug companies
9 distributed 76,000,000,000 oxycodone and
10 hydrocodone pain pills nationwide from 2006 to
11 2012.

12 (2) The combination of a rising number of pre-
13 scriptions, misinformation about the addictive prop-
14 erties of prescription opioids, and the perception
15 that prescription drugs are less harmful than illicit
16 drugs has caused an increase in drug misuse.

17 (3) As legitimate production and illegal diver-
18 sion of opioids skyrocketed, so did the number of
19 opioid overdose deaths. From 1999 to 2017, almost
20 218,000 people died in the United States from
21 overdoses related to prescription opioids. More re-
22 cently, fentanyl, a powerful synthetic opioid, sur-
23 passed prescription opioids as the most lethal over-
24 dose substance and now is linked to nearly 3 times
25 as many deaths.

26 (4) The scale of the opioid crisis is staggering:

1 (A) In 2018, approximately 10,300,000
2 people in the United States age 12 and older
3 misused opioids.

4 (B) On average, 130 people in the United
5 States die every day from an opioid overdose.

6 (C) The opioid crisis has cost the United
7 States economy at least \$631,000,000,000.

8 (D) From 2013 to 2017, the number of
9 children in foster care nationwide increased 10
10 percent to nearly 442,995. Parental drug use
11 was cited as a factor in 36 percent of cases.

12 (5) The opioid crisis has also led to a cascade
13 of other negative health impacts. For example, sy-
14 ringe sharing among people who inject drugs has led
15 to increases in hepatitis C virus infections and infec-
16 tive endocarditis, as well as localized HIV outbreaks.

17 (6) The United States health care system has
18 struggled to catch up to the crisis:

19 (A) The majority of people in the United
20 States with an opioid use disorder do not re-
21 ceive substance use treatment, and many who
22 do receive such treatment do not receive evi-
23 dence-based treatment. Although medication-as-
24 sisted treatment has been endorsed by the Na-
25 tional Institutes of Health and the World

1 Health Organization, only one-third of treat-
2 ment programs offer any of the 3 drugs ap-
3 proved by the Food and Drug Administration
4 for the treatment of opioid use disorder, and
5 just 6 percent of medication-offering facilities
6 provide all 3.

7 (B) Facilities that provide medications for
8 the treatment of opioid disorder are con-
9 centrated in the Northeast and Southwest, leav-
10 ing many of the areas hit hardest by the opioid
11 crisis without access to evidence-based treat-
12 ment. The need is particularly acute in rural
13 areas, which often do not have enough providers
14 to meet the demand.

15 (C) Unlike other health care needs, sub-
16 stance use treatment is largely funded by State
17 and local revenues and Federal block grants,
18 rather than the Medicare program, the Med-
19 icaid program, and private insurance.

20 (D) While new substances, particularly
21 synthetic drugs, continue to make inroads into
22 communities in the United States, funding
23 streams are often dedicated to particular sub-
24 stances, limiting providers' ability to adapt to
25 changing needs.

1 (E) The stigma associated with substance
2 use disorder prevents people from seeking treat-
3 ment. Too often, people enter substance use
4 treatment only after committing a criminal of-
5 fense, whether through a court mandate, as a
6 condition of parole or probation supervision, or
7 as a condition of regaining employment after
8 conviction. In 2003, 36 percent of all substance
9 use treatment admissions, 40 percent of all al-
10 cohol abuse treatment admissions, and 57 per-
11 cent of all marijuana use treatment admissions
12 were referrals from the criminal justice system.

13 (F) The stigma of substance use disorder
14 also limits people's ability to find jobs and
15 housing. These obstacles are exacerbated by the
16 criminalization of substance use disorder—even
17 convictions for drug possession for personal use
18 can create lifelong collateral consequences. The
19 absence of stable housing and employment
20 make it even more difficult for people to live
21 drug free.

22 (7) Not all people in the United States have
23 equal access to substance use treatment in the com-
24 munity. Current research has found that Black and
25 Latinx Americans are less likely to receive substance

1 use treatment when controlling for other relevant
2 factors, like socioeconomic status.

3 (8) Inadequate access to substance use treat-
4 ment can exacerbate other health disparities. Indi-
5 viduals with substance use disorders have higher
6 rates of suicide attempts than individuals in the gen-
7 eral population, high health care expenses, and sig-
8 nificant disability.

9 (9) A comprehensive public health approach
10 that tackles both the causes and the consequences of
11 substance use disorder is necessary to stem the tide.

12 **TITLE I—RESEARCH,** 13 **EDUCATION, AND PREVENTION**

14 **SEC. 101. NATIONAL EDUCATION CAMPAIGN.**

15 Section 102 of the Comprehensive Addiction and Re-
16 covery Act of 2016 (42 U.S.C. 290bb–25g) is amended—

17 (1) in subsection (a), by inserting “or other
18 controlled substances (as defined in section 102 of
19 the Controlled Substances Act (21 U.S.C. 802))”
20 after “opioids” each place such term appears;

21 (2) in subsection (b), by striking “opioid” each
22 place it appears and inserting “substance”;

23 (3) in subsection (c)—

24 (A) in paragraph (2), by striking “and” at
25 the end;

1 (B) in paragraph (3), by striking the pe-
 2 riod and inserting a semicolon; and

3 (C) by adding at the end the following:

4 “(4) use destigmatizing language promoting hu-
 5 mane and culturally competent (as defined in section
 6 102 of the Developmental Disabilities Assistance
 7 and Bill of Rights Act of 2000 (42 U.S.C. 15002))
 8 treatment of all individuals who face substance use
 9 disorder, including such individuals who use medica-
 10 tion-assisted treatment for recovery purposes;

11 “(5) educate stakeholders on the evidence base
 12 and validation of harm reduction and where to ob-
 13 tain harm reduction services;

14 “(6) include information about polysubstance
 15 use; and

16 “(7) include information about prevention and
 17 treatment using medication-assisted treatment and
 18 recovery.”; and

19 (4) by adding at the end the following:

20 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
 21 is authorized to be appropriated to carry out this section
 22 such sums as may be necessary for each of fiscal years
 23 2021 through 2026.”.

1 **SEC. 102. RESEARCH INTO NON-OPIOID PAIN MANAGE-**
2 **MENT.**

3 (a) IN GENERAL.—The Secretary of Health and
4 Human Services, acting through the Director of the Na-
5 tional Institutes of Health and the Director of the Centers
6 for Disease Control and Prevention, shall carry out re-
7 search with respect to non-opioid methods of pain manage-
8 ment, including non-pharmaceutical remedies for pain and
9 integrative medicine solutions.

10 (b) AUTHORIZATION OF APPROPRIATIONS.—To carry
11 out this section, there are authorized to be appropriated
12 such sums as may be necessary for each of fiscal years
13 2021 through 2026.

14 **SEC. 103. LONG-TERM TREATMENT OUTCOMES RESEARCH.**

15 (a) IN GENERAL.—The Secretary of Health and
16 Human Services shall award grants to eligible entities to
17 carry out evidence-based, long-term outcomes research,
18 over 5-year periods, for different modalities of treatment
19 for substance use disorder. Such research shall measure
20 mortality, morbidity, physical and emotional health, em-
21 ployment, stable housing, criminal justice involvement,
22 family relationships, and other quality-of-life measures.
23 Such research shall distinguish outcomes based on race,
24 gender, and socioeconomic status, as well as any other rel-
25 evant characteristics.

1 (b) AUTHORIZATION OF APPROPRIATIONS.—To carry
2 out this section, there are authorized to be appropriated
3 such sums as may be necessary.

4 **SEC. 104. NATIONAL COMMISSION FOR EXCELLENCE ON**
5 **POST-OVERDOSE RESPONSE.**

6 (a) IN GENERAL.—The Assistant Secretary of Health
7 and Human Services for Mental Health and Substance
8 Use (referred to in this section as the “Assistant Sec-
9 retary”), in consultation with the Director of the Office
10 of National Drug Control Policy, and the President of the
11 National Academy of Medicine, shall establish an advisory
12 commission, to be known as the “National Commission for
13 Excellence on Post-Overdose Response”, that—

14 (1) provides evidence, practical tools, and other
15 resources for researchers and evaluators, clinicians
16 and clinical teams, quality improvement experts, and
17 healthcare decision makers to improve the quality
18 and safety of care for drug overdoses and substance
19 use disorder;

20 (2) advises the individuals described in para-
21 graph (1) on—

22 (A) how to achieve equitable outcomes
23 across race and socioeconomic status; and

24 (B) how to effectively and appropriately
25 control avoidable hospital admissions, emer-

1 agency department admissions, and other ad-
2 verse events related to substance use disorder
3 care; and

4 (3) develops culturally competent (as defined in
5 section 102 of the Developmental Disabilities Assist-
6 ance and Bill of Rights Act of 2000 (42 U.S.C.
7 15002)) best practices and clinical practice guide-
8 lines.

9 (b) MEMBERSHIP.—The members of the commission
10 established under subsection (a) shall include—

11 (1) a representative of the Substance Abuse
12 and Mental Health Services Administration;

13 (2) a representative of the Office of National
14 Drug Control Policy;

15 (3) a representative of the National Academy of
16 Medicine;

17 (4) a representative of the National Institute on
18 Drug Abuse;

19 (5) a substance use disorder specialist ap-
20 pointed by the Assistant Secretary;

21 (6) a peer recovery specialist appointed by the
22 Assistant Secretary; and

23 (7) any other individual that the Assistant Sec-
24 retary determines appropriate.

1 (c) SUNSET.—The commission established under sub-
 2 section (a) shall terminate on the date that is 10 years
 3 after the date of enactment of this Act.

4 **SEC. 105. WORKFORCE FOR PREVENTION.**

5 Subpart 2 of part B of title V of the Public Health
 6 Service Act (42 U.S.C. 290bb–21 et seq.) is amended by
 7 adding at the end the following:

8 **“SEC. 519E. EMPLOYMENT AND TRAINING SERVICES.**

9 “(a) IN GENERAL.—The Director of the Prevention
 10 Center shall—

11 “(1) not later than 30 days after the date of
 12 enactment of this Act, announce an opportunity to
 13 apply for grants or contracts awarded to support the
 14 activities described in subsection (b); and

15 “(2) from the funds appropriated under sub-
 16 section (c), not later than 45 days after the date on
 17 which an entity submits an application that meets
 18 the requirements of the Secretary under this section,
 19 award funds under this section to such entity.

20 “(b) USE OF FUNDS.—An entity that receives funds
 21 under this section shall use the funds to support employ-
 22 ment and training services for substance use treatment
 23 professionals, including peer recovery specialists.

24 “(c) AUTHORIZATION OF APPROPRIATIONS.—There
 25 are authorized to be appropriated to carry out this section

1 such sums as may be necessary for each of fiscal years
 2 2021 through 2026.”.

3 **SEC. 106. REAUTHORIZATION OF COMMUNITY-BASED COA-**
 4 **LITION ENHANCEMENT GRANTS TO ADDRESS**
 5 **LOCAL DRUG CRISES.**

6 Section 103(i) of the Comprehensive Addiction and
 7 Recovery Act of 2016 (21 U.S.C. 1536(i)) is amended by
 8 striking “there are authorized to be appropriated
 9 \$5,000,000 for each of fiscal years 2017 through 2021.”
 10 and inserting the following: “there are authorized to be
 11 appropriated—

12 “(1) \$5,000,000 for each of fiscal years 2017
 13 through 2020; and

14 “(2) \$10,000,000 for each of fiscal years 2021
 15 through 2026.”.

16 **TITLE II—TREATMENT**

17 **SEC. 201. THREE-DAY LIMIT ON OPIOID PRESCRIPTIONS.**

18 Section 303 of the Controlled Substances Act (21
 19 U.S.C. 823) is amended by adding at the end the fol-
 20 lowing:

21 “(1) **THREE-DAY LIMIT ON OPIOID PRESCRIP-**
 22 **TIONS.—**

23 “(1) **DEFINITIONS.—**In this subsection—

24 “(A) the term ‘acute pain’—

1 “(i) means pain with abrupt onset and
 2 caused by an injury or other process that
 3 is not ongoing; and

4 “(ii) does not include—

5 “(I) chronic pain;

6 “(II) pain being treated as part
 7 of cancer care;

8 “(III) hospice or other end-of-life
 9 care; or

10 “(IV) pain being treated as part
 11 of palliative care; and

12 “(B) the term ‘substance use treatment
 13 opioid prescription’ means a prescription—

14 “(i) for an opioid drug in schedule II,
 15 III, or IV approved by the Food and Drug
 16 Administration for an indication for the
 17 treatment of substance use disorder; and

18 “(ii) that is for the treatment of sub-
 19 stance use disorder.

20 “(2) THREE-DAY LIMIT.—The Attorney General
 21 may not register, or renew the registration of, a
 22 practitioner under subsection (f) who is licensed
 23 under State law to prescribe controlled substances in
 24 schedule II, III, or IV, unless the practitioner sub-
 25 mits to the Attorney General, for each such registra-

tion or renewal request, a certification that the practitioner, during the applicable registration period, will not prescribe any opioid in schedule II, III, or IV, other than a substance use disorder treatment opioid prescription, for the initial treatment of acute pain in an amount in excess of a 3-day supply.”.

**SEC. 202. EVIDENCE-BASED SUBSTANCE USE DISORDER
TREATMENT AND INTERVENTION DEMONSTRATIONS.**

Section 514B of the Public Health Service Act (42 U.S.C. 290bb–10) is amended—

(1) in subsection (a), by adding at the end the following:

“(3) USE OF FUNDS FOR TRAINING.—Funds awarded under paragraph (1) may be used by a recipient for training emergency room technicians, physicians, nurses, or other health care professionals on identifying the presence of substance use disorders, and how effectively to engage with, intervene with respect to, and refer patients for assessment and specialized substance use disorder care, including medication-assisted treatment and care for co-occurring disorders.”;

(2) in subsection (d), by inserting “, and Indian tribes and tribal organizations (as defined in section

1 4 of the Indian Self-Determination and Education
 2 Assistance Act)” before the period of the first sen-
 3 tence; and

4 (3) in subsection (f), by inserting before the pe-
 5 riod the following: “, and \$300,000,000 for each of
 6 fiscal years 2021 through 2026”.

7 **SEC. 203. NATIONAL YOUTH AND YOUNG ADULT RECOVERY**
 8 **INITIATIVE.**

9 (a) DEFINITIONS.—In this section:

10 (1) ELIGIBLE ENTITY.—The term “eligible enti-
 11 ty” means—

12 (A) a high school that has been accredited
 13 as a substance use recovery high school or that
 14 is seeking to establish or expand substance use
 15 recovery support services;

16 (B) an institution of higher education;

17 (C) a recovery program at an institution of
 18 higher education;

19 (D) a nonprofit organization; or

20 (E) a technical assistance center that can
 21 help grantees install recovery support service
 22 programs aimed at youth and young adults
 23 which include recovery coaching, job training,
 24 transportation, linkages to community-based
 25 services and supports, regularly scheduled alter-

1 native peer group activities, life-skills education,
2 mentoring, and leadership development.

3 (2) HIGH SCHOOL.—The term “high school”
4 has the meaning given the term in section 8101 of
5 the Elementary and Secondary Education Act of
6 1965 (20 U.S.C. 7801).

7 (3) INSTITUTION OF HIGHER EDUCATION.—The
8 term “institution of higher education” has the
9 meaning given the term in section 101 of the Higher
10 Education Act of 1965 (20 U.S.C. 1001).

11 (4) RECOVERY PROGRAM.—The term “recovery
12 program” means a program—

13 (A) to help youth or young adults who are
14 recovering from substance use disorders to ini-
15 tiate, stabilize, and maintain healthy and pro-
16 ductive lives in the community; and

17 (B) that includes peer-to-peer support de-
18 livered by individuals with lived experience in
19 recovery, and communal activities to build re-
20 covery skills and supportive social networks.

21 (b) GRANTS AUTHORIZED.—The Assistant Secretary
22 for Mental Health and Substance Use, in consultation
23 with the Secretary of Education, shall award grants, on
24 a competitive basis, to eligible entities to enable the eligi-
25 ble entities to—

1 (1) provide culturally competent (as defined in
2 section 102 of the Developmental Disabilities Assist-
3 ance and Bill of Rights Act of 2000 (42 U.S.C.
4 15002)) substance use recovery support services to
5 youth and young adults enrolled in high school or an
6 institution of higher education;

7 (2) help build communities of support for youth
8 and young adults in substance use recovery through
9 a spectrum of activities such as counseling, job
10 training, recovery coaching, alternative peer groups,
11 life-skills workshops, family support groups, and
12 health and wellness-oriented social activities; and

13 (3) encourage initiatives designed to help youth
14 and young adults achieve and sustain recovery from
15 substance use disorders.

16 (c) APPLICATION.—An eligible entity desiring a grant
17 under this section shall submit to the Assistant Secretary
18 for Mental Health and Substance Use an application at
19 such time, in such manner, and containing such informa-
20 tion as the Assistant Secretary may require.

21 (d) PREFERENCE.—In awarding grants under sub-
22 section (b), the Assistant Secretary for Mental Health and
23 Substance Use shall give preference to eligible entities that
24 propose to serve students from areas with schools serving
25 a high percentage of children who are counted under sec-

1 tion 1124(c) of the Elementary and Secondary Education
2 Act of 1965 (20 U.S.C. 6333(c)).

3 (e) USE OF FUNDS.—Grants awarded under sub-
4 section (b) may be used for activities to develop, support,
5 or maintain substance use recovery support services for
6 youth or young adults, including—

7 (1) the development and maintenance of a dedi-
8 cated physical space for recovery programs;

9 (2) hiring dedicated staff for the provision of
10 recovery programs;

11 (3) providing health and wellness-oriented social
12 activities and community engagement;

13 (4) the establishment of a substance use recov-
14 ery high school;

15 (5) the coordination of a peer delivered sub-
16 stance use recovery program with—

17 (A) substance use disorder treatment pro-
18 grams and systems that utilize culturally com-
19 petent (as defined in section 102 of the Devel-
20 opmental Disabilities Assistance and Bill of
21 Rights Act of 2000 (42 U.S.C. 15002)) services
22 that reflect the communities they serve;

23 (B) providers of mental health services;

24 (C) primary care providers;

1 (D) the criminal justice system, including
2 the juvenile justice system;

3 (E) employers;

4 (F) recovery housing services;

5 (G) child welfare services;

6 (H) high schools; and

7 (I) institutions of higher education;

8 (6) the development of peer-to-peer support
9 programs or services delivered by individuals with
10 lived experience in substance use disorder recovery;
11 and

12 (7) any additional activity that helps youth or
13 young adults achieve recovery from substance use
14 disorders.

15 (f) RESOURCE CENTER.—The Assistant Secretary
16 for Mental Health and Substance Use shall establish a re-
17 source center to provide technical support to recipients of
18 grants under this section.

19 (g) AUTHORIZATION OF APPROPRIATIONS.—There
20 are authorized to be appropriated \$10,000,000 for each
21 of fiscal years 2021 through 2026.

22 **SEC. 204. IMPROVING TREATMENT FOR PREGNANT,**
23 **POSTPARTUM, AND PARENTING WOMEN.**

24 Section 508 of the Public Health Service Act (42
25 U.S.C. 290bb–1) is amended—

1 (1) in subsection (m)—

2 (A) by striking “shall give priority” and
3 inserting “shall give—
4 “(1) priority”;

5 (B) by striking the period at the end and
6 inserting “; and”; and

7 (C) by adding at the end the following:

8 “(2) preference to an applicant that agrees to—

9 “(A) allow participation in the program
10 supported by the award by individuals taking a
11 drug or combination of drugs approved by the
12 Food and Drug Administration for medication-
13 assisted treatment, including such individuals
14 taking an opioid agonist;

15 “(B) provide culturally competent services
16 (as defined in section 102 of the Developmental
17 Disabilities Assistance and Bill of Rights Act of
18 2000);

19 “(C) ensure flexible lengths of stay in the
20 treatment program; and

21 “(D) use peer recovery advocates in the
22 program supported by the award.”;

23 (2) in subsection (p), by inserting “, and demo-
24 graphic data on the individuals served by programs
25 funded under this section and case outcomes, as re-

ported to the Director by award recipients” before the period at the end of the third sentence; and

(3) in subsection (s), by striking “\$29,931,000 for each of fiscal years 2019 through 2023” and inserting “100,000,000 for each of fiscal years 2021 through 2026”.

SEC. 205. REQUIRE THE USE OF PRESCRIPTION DRUG MONITORING PROGRAMS.

(a) DEFINITIONS.—In this section:

(1) CONTROLLED SUBSTANCE.—The term “controlled substance” has the meaning given the term in section 102 of the Controlled Substances Act (21 U.S.C. 802).

(2) COVERED STATE.—The term “covered State” means a State that receives funding under the Harold Rogers Prescription Drug Monitoring Program established under the Departments of Commerce, Justice, and State, the Judiciary, and Related Agencies Appropriations Act, 2002 (Public Law 107–77; 115 Stat. 748), under this Act (or an amendment made by this Act), or under the controlled substance monitoring program under section 399O of the Public Health Service Act (42 U.S.C. 280g–3).

(3) DISPENSER.—The term “dispenser”—

1 (A) means a person licensed or otherwise
2 authorized by a State to deliver a prescription
3 drug product to a patient or an agent of the pa-
4 tient; and

5 (B) does not include a person involved in
6 oversight or payment for prescription drugs.

7 (4) PDMP.—The term “PDMP” means a pre-
8 scription drug monitoring program.

9 (5) PRACTITIONER.—The term “practitioner”
10 means a practitioner registered under section 303(f)
11 of the Controlled Substances Act (21 U.S.C. 823(f))
12 to prescribe, administer, or dispense controlled sub-
13 stances.

14 (6) STATE.—The term “State” means each of
15 the several States and the District of Columbia.

16 (b) IN GENERAL.—Beginning 1 year after the date
17 of enactment of this Act, each covered State shall re-
18 quire—

19 (1) each prescribing practitioner within the cov-
20 ered State or their designee, who shall be licensed or
21 registered healthcare professionals or other employ-
22 ees who report directly to the practitioner, to consult
23 the PDMP of the covered State before initiating
24 treatment with a prescription for a controlled sub-
25 stance listed in schedule II, III, or IV of section

1 202(c) of the Controlled Substances Act (21 U.S.C.
2 812(c)), and every 3 months thereafter as long as
3 the treatment continues;

4 (2) the PDMP of the covered State to provide
5 proactive notification to a practitioner when patterns
6 indicative of controlled substance misuse, including
7 opioid misuse, are detected;

8 (3) each dispenser within the covered State to
9 report each prescription for a controlled substance
10 dispensed by the dispenser to the PDMP not later
11 than 24 hours after the controlled substance is dis-
12 pensed to the patient;

13 (4) that the PDMP make available a quarterly
14 de-identified data set and an annual report for pub-
15 lic and private use, including use by healthcare pro-
16 viders, health plans and health benefits administra-
17 tors, State agencies, and researchers, which shall, at
18 a minimum, meet requirements established by the
19 Attorney General, in coordination with the Secretary
20 of Health and Human Services;

21 (5) each State agency that administers the
22 PDMP to—

23 (A) proactively analyze data available
24 through the PDMP; and

1 (B) provide reports to prescriber licensing
2 boards describing any prescribing practitioner
3 that repeatedly fall outside of expected norms
4 or standard practices for the prescribing practi-
5 tioner's field; and

6 (6) that the data contained in the PDMP of the
7 covered State be made available to other States.

8 (c) NONCOMPLIANCE.—If a covered State fails to
9 comply with subsection (a), the Attorney General or the
10 Secretary of Health and Human Services may withhold
11 grant funds from being awarded to the covered State
12 under the Harold Rogers Prescription Drug Monitoring
13 Program established under the Departments of Com-
14 merce, Justice, and State, the Judiciary, and Related
15 Agencies Appropriations Act, 2002 (Public Law 107–77;
16 115 Stat. 748), under this Act (or an amendment made
17 by this Act), or under the controlled substance monitoring
18 program under section 3990 of the Public Health Service
19 Act (42 U.S.C. 280g–3).

20 **SEC. 206. PRESCRIBER EDUCATION.**

21 (a) IN GENERAL.—Section 303 of the Controlled
22 Substances Act (21 U.S.C. 823), as amended by section
23 201, is amended—

24 (1) in subsection (f), in the matter preceding
25 paragraph (1), by striking “The Attorney General

1 shall register” and inserting “Subject to subsection
 2 (m), the Attorney General shall register”; and

3 (2) by adding at the end the following:

4 “(m) PRESCRIBER EDUCATION.—

5 “(1) DEFINITIONS.—In this subsection—

6 “(A) the term ‘covered agent or employee’
 7 means an agent or employee of a covered facil-
 8 ity who—

9 “(i) prescribes controlled substances
 10 for humans under the registration of the
 11 facility under this part; and

12 “(ii) is a medical resident;

13 “(B) the term ‘covered facility’ means a
 14 practitioner—

15 “(i) that is a hospital or other institu-
 16 tion;

17 “(ii) that is licensed under State law
 18 to prescribe controlled substances; and

19 “(iii) under whose registration under
 20 this part agents or employees of the practi-
 21 tioner prescribe controlled substances;

22 “(C) the term ‘covered individual practi-
 23 tioner’ means a practitioner who—

24 “(i) is an individual;

25 “(ii) is not a veterinarian; and

1 “(iii) is licensed under State law to
 2 prescribe controlled substances; and

3 “(D) the term ‘specified continuing edu-
 4 cation topics’ means—

5 “(i) alternatives to opioids for pain
 6 management;

7 “(ii) palliative care;

8 “(iii) substance use disorder;

9 “(iv) adverse events;

10 “(v) potential for dependence;

11 “(vi) tolerance;

12 “(vii) prescribing contraindicated sub-
 13 stances;

14 “(viii) medication-assisted treatment;

15 “(ix) culturally competent (as defined
 16 in section 102 of the Developmental Dis-
 17 abilities Assistance and Bill of Rights Act
 18 of 2000 (42 U.S.C. 15002)) services;

19 “(x) bias and stigma in prescribing
 20 trends; and

21 “(xi) any other topic that the Attor-
 22 ney General determines appropriate.

23 “(2) CERTIFICATION OF CONTINUING EDU-
 24 CATION.—

1 “(A) INDIVIDUAL PRACTITIONERS.—As a
2 condition of granting or renewing the registra-
3 tion of a covered individual practitioner under
4 this part to dispense controlled substances in
5 schedule II, III, IV, or V, the Attorney General
6 shall require the practitioner to certify that,
7 during the 3-year period preceding the date of
8 the grant or renewal of registration, the practi-
9 tioner completed course work or training from
10 an organization accredited by the Accreditation
11 Council for Continuing Medical Education
12 (commonly known as the ‘ACCME’), or by a
13 State medical society accreditor recognized by
14 the ACCME, that included not fewer than 3
15 hours of content on the specified continuing
16 education topics.

17 “(B) FACILITIES.—As a condition of
18 granting or renewing the registration of a cov-
19 ered facility under this part to dispense con-
20 trolled substances in schedule II, III, IV, or V,
21 the Attorney General shall require the covered
22 facility to certify that the facility does not allow
23 a covered agent or employee to prescribe con-
24 trolled substances for humans under the reg-
25 istration of the facility unless, during the pre-

ceding 3-year period, the covered agent or employee completed course work or training from an organization accredited by the Accreditation Council for Continuing Medical Education (commonly known as the ‘ACCME’), or a State medical society accreditor recognized by the ACCME, that included not fewer than 3 hours of content on the specified continuing education topics.”.

(b) EFFECTIVE DATE.—Subsection (m) of section 303 of the Controlled Substances Act (21 U.S.C. 823), as added by subsection (a), shall apply to any grant or renewal of registration described in such subsection (m) that occurs on or after the date that is 2 years after the date of enactment of this Act.

SEC. 207. PROHIBITION OF UTILIZATION CONTROL POLICIES OR PROCEDURES FOR MEDICATION-ASSISTED TREATMENT UNDER MEDICAID.

Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(1) in subsection (a)—

(A) in the matter preceding paragraph (1), by moving the margin of clause (xvi) 4 ems to the left; and

1 (B) in paragraph (29), by inserting “and
 2 to the extent allowed in paragraph (3) of such
 3 subsection” after “paragraph (1) of such sub-
 4 section”; and
 5 (2) in subsection (ee), by adding at the end the
 6 following new paragraph:

7 “(3) PROHIBITION OF UTILIZATION CONTROL
 8 POLICIES OR PROCEDURES FOR MEDICATION-AS-
 9 SISTED TREATMENT.—As a condition for a State re-
 10 ceiving payments under section 1903(a) for medical
 11 assistance for medication-assisted treatment, a State
 12 may not impose any utilization control policies or
 13 procedures (as defined by the Secretary), including
 14 prior authorization requirements, with respect to
 15 such treatment.”.

16 **SEC. 208. PILOT PROGRAM ON EXPANDING ACCESS TO**
 17 **TREATMENT.**

18 The Secretary of Health and Human Services (re-
 19 ferred to in this section as the “Secretary”) shall establish
 20 a 5-year pilot program in not less than 5 diverse regions
 21 to study the use of mobile methadone clinics in rural and
 22 underserved environments. At the end of the pilot pro-
 23 gram, the Secretary shall report to Congress on the pro-
 24 gram outcomes, including the number of people served and

1 the demographics of people served, including race and in-
 2 come.

3 **SEC. 209. REAUTHORIZATION OF PRACTICER EDUCATION GRANT PRO-**
 4 **GRAM.**

5 To carry out the Practitioner Education grant pro-
 6 gram established by the Substance Abuse and Mental
 7 Health Services Administration, there is authorized to be
 8 appropriated such sums as may be necessary for each of
 9 fiscal years 2021 through 2026.

10 **TITLE III—RECOVERY**
 11 **Subtitle A—General Provisions**

12 **SEC. 301. BUILDING COMMUNITIES OF RECOVERY.**

13 (a) IN GENERAL.—Section 547 of the Public Health
 14 Service Act (42 U.S.C. 290ee–2) is amended—

15 (1) by striking subsection (c);

16 (2) by redesignating subsection (d) as sub-
 17 section (c);

18 (3) in subsection (c) (as so redesignated)—

19 (A) in paragraph (1), by striking “and” at
 20 the end;

21 (B) in paragraph (2)(C)(iv), by striking
 22 the period and inserting “; and”; and

23 (C) by adding at the end the following:

24 “(3) may be used as provided for in subsection
 25 (d).”;

1 (4) by inserting after subsection (c) (as so re-
2 designated), the following:

3 “(d) ESTABLISHMENT OF REGIONAL TECHNICAL AS-
4 SISTANCE CENTERS.—

5 “(1) IN GENERAL.—Grants awarded under sub-
6 section (b) may be used to provide for the establish-
7 ment of regional technical assistance centers to pro-
8 vide regional technical assistance for the following:

9 “(A) Implementation of regionally driven
10 peer delivered substance use disorder recovery
11 support services before, during, after, or in lieu
12 of substance use disorder treatment.

13 “(B) Establishment of recovery community
14 organizations.

15 “(C) Establishment of recovery community
16 centers.

17 “(D) Naloxone training and dissemination.

18 “(E) Development of connections between
19 recovery support services, community organiza-
20 tions, and community centers and the broader
21 medical community.

22 “(F) Establishment of online recovery sup-
23 port services, with parity to physical health
24 services.

1 “(G) Development of recovery wellness
2 plans to address perceived barriers to recovery,
3 including social determinants of health.

4 “(H) Establishment of culturally com-
5 petent (as defined in section 102 of the Devel-
6 opmental Disabilities Assistance and Bill of
7 Rights Act of 2000) treatment programs to en-
8 gage with racially and ethnically diverse pa-
9 tients.

10 “(2) ELIGIBLE ENTITIES.—To be eligible to re-
11 ceive a grant under paragraph (1), an entity shall
12 be—

13 “(A) a national nonprofit entity with a net-
14 work of local affiliates and partners that are
15 geographically and organizationally diverse; or

16 “(B) a national nonprofit organization es-
17 tablished by individuals in personal and family
18 recovery, serving prevention, treatment, recov-
19 ery, payor, faith-based, and criminal justice
20 stakeholders in the implementation of local sub-
21 stance use disorder and recovery initiatives.

22 “(3) PREFERENCE.—In awarding grants under
23 subsection (b), the Secretary shall give preference to
24 organizations that—

1 “(A) provide culturally competent (as de-
 2 fined in section 102 of the Developmental Dis-
 3 abilities Assistance and Bill of Rights Act of
 4 2000) services;

5 “(B) allow participation by individuals re-
 6 ceiving medication-assisted treatment that in-
 7 volves prescription drugs approved by the Food
 8 and Drug Administration (at least one of which
 9 is an opioid agonist); and

10 “(C) use peer recovery advocates.”; and

11 (5) in subsection (f), by striking “2023” and
 12 inserting “2020, and \$200,000,000 for each of fiscal
 13 years 2021 through 2026”.

14 (b) CONTINUING CARE AND COMMUNITY SUPPORT
 15 TO MAINTAIN RECOVERY.—

16 (1) IN GENERAL.—The Secretary shall award
 17 grants to peer recovery support services, for the pur-
 18 poses of providing continuing care and ongoing com-
 19 munity support for individuals to maintain recovery
 20 from substance use disorders.

21 (2) DEFINITION.—For purposes of this sub-
 22 section, the term “peer recovery support services”
 23 means an independent nonprofit organization that
 24 provides peer recovery support services, through
 25 credentialed peer support professionals.

1 (3) AUTHORIZATION OF APPROPRIATIONS.—

2 There are authorized to be appropriated, for each of
3 fiscal years 2021 through 2026, \$50,000,000 for
4 purposes of awarding grants under paragraph (1).

5 **SEC. 302. MEDICATION-ASSISTED TREATMENT FOR RECOV-**
6 **ERY FROM SUBSTANCE USE DISORDER.**

7 (a) IN GENERAL.—Section 303(g) of the Controlled
8 Substances Act (21 U.S.C. 823(g)) is amended—

9 (1) by striking paragraph (2);

10 (2) by striking “(g)(1) Except as provided in
11 paragraph (2), practitioners who dispense narcotic
12 drugs to individuals for maintenance treatment or
13 detoxification treatment” and inserting “(g) Practi-
14 tioners who dispense narcotic drugs (other than nar-
15 cotic drugs in schedule III, IV, or V) to individuals
16 for maintenance treatment or detoxification treat-
17 ment”;

18 (3) by redesignating subparagraphs (A), (B),
19 and (C) as paragraphs (1), (2), and (3), respectively;
20 and

21 (4) in paragraph (2), as redesignated, by redes-
22 ignating clauses (i) and (ii) as subparagraphs (A)
23 and (B), respectively.

24 (b) TECHNICAL AND CONFORMING EDITS.—

1 (1) Section 304 of the Controlled Substances
2 Act (21 U.S.C. 824) is amended—

3 (A) in subsection (a), by striking
4 “303(g)(1)” each place it appears and inserting
5 “303(g)”; and

6 (B) in subsection (d)(1), by striking
7 “303(g)(1)” and inserting “303(g)”.

8 (2) Section 309A(a) of the Controlled Sub-
9 stances Act (21 U.S.C. 829a(a)) is amended by
10 striking paragraph (2) and inserting the following:

11 “(2) the controlled substance—

12 “(A) is a narcotic drug in schedule III, IV,
13 or V to be administered for the purpose of
14 maintenance or detoxification treatment; and

15 “(B) is to be administered by injection or
16 implantation;”.

17 (3) Section 520E–4(c) of the Public Health
18 Service Act (42 U.S.C. 290bb–36d(c)) is amended,
19 in the matter preceding paragraph (1), by striking
20 “information on any qualified practitioner that is
21 certified to prescribe medication for opioid depend-
22 ency under section 303(g)(2)(B) of the Controlled
23 Substances Act” and inserting “information on any
24 practitioner who prescribes narcotic drugs in sched-
25 ule III, IV, or V of section 202 of the Controlled

1 Substances Act for the purpose of maintenance or
2 detoxification treatment”.

3 (4) Section 544(a)(3) of the Public Health
4 Service Act (42 U.S.C. 290dd–3) is amended by
5 striking “any practitioner dispensing narcotic drugs
6 pursuant to section 303(g) of the Controlled Sub-
7 stances Act” and inserting “any practitioner dis-
8 pensing narcotic drugs for the purpose of mainte-
9 nance or detoxification treatment”.

10 (5) Section 1833(bb)(3)(B) of the Social Secu-
11 rity Act (42 U.S.C. 1395l(bb)(3)(B)) is amended by
12 striking “first receives a waiver under section 303(g)
13 of the Controlled Substances Act on or after Janu-
14 ary 1, 2019” and inserting “first begins prescribing
15 narcotic drugs in schedule III, IV, or V of section
16 202 of the Controlled Substances Act for the pur-
17 pose of maintenance or detoxification treatment on
18 or after January 1, 2019”.

19 (6) Section 1834(o)(3)(C)(ii) of the Social Se-
20 curity Act (42 U.S.C. 1395m(o)(3)(C)(ii)) is amend-
21 ed by striking “first receives a waiver under section
22 303(g) of the Controlled Substances Act on or after
23 January 1, 2019” and inserting “first begins pre-
24 scribing narcotic drugs in schedule III, IV, or V of
25 section 202 of the Controlled Substances Act for the

1 purpose of maintenance or detoxification treatment
2 on or after January 1, 2019”.

3 (7) Section 1866F(c)(3) of the Social Security
4 Act (42 U.S.C. 1395cc–6(c)(3)) is amended—

5 (A) in subparagraph (A), by inserting
6 “and” at the end;

7 (B) in subparagraph (B), by striking “;
8 and” and inserting a period; and

9 (C) by striking subparagraph (C).

10 (8) Section 1903(aa)(2)(C) of the Social Secu-
11 rity Act (42 U.S.C. 1396b(aa)(2)(C)) is amended—

12 (A) in clause (i), by inserting “and” at the
13 end;

14 (B) by striking clause (ii); and

15 (C) by redesignating clause (iii) as clause
16 (ii).

17 **SEC. 303. RECOVERY IN THE WORKPLACE.**

18 It is the sense of Congress that an employee who is
19 taking opioid antagonist, opioid agonist, or partial agonist
20 drugs as part of a medication-assisted treatment program
21 shall not be in violation of a drug-free workplace require-
22 ment.

1 **SEC. 304. TELEHEALTH FOR RECOVERY SUPPORT SERV-**
 2 **ICES.**

3 (a) FUNDING FOR THE TESTING OF INCENTIVE PAY-
 4 MENTS FOR BEHAVIORAL HEALTH PROVIDERS FOR
 5 ADOPTION AND USE OF CERTIFIED ELECTRONIC
 6 HEALTH RECORD TECHNOLOGY.—In addition to amounts
 7 appropriated under subsection (f) of section 1135A of the
 8 Social Security Act (42 U.S.C. 13951315a), there are au-
 9 thorized to be appropriated to the Center for Medicare and
 10 Medicaid Innovation such sums as may be necessary for
 11 fiscal year 2021 to design, implement, and evaluate the
 12 model under subsection (b)(2)(B)(xxv) of such section.
 13 Amounts appropriated under the preceding sentence shall
 14 remain available until expended.

15 (b) TELEHEALTH FOR SUBSTANCE USE DISORDER
 16 TREATMENT.—

17 (1) SUBSTANCE USE DISORDER SERVICES FUR-
 18 NISHED THROUGH TELEHEALTH UNDER MEDI-
 19 CARE.—Section 1834(m)(7) of the Social Security
 20 Act (42 U.S.C. 1395m(m)(7)) is amended by adding
 21 at the end the following: “With respect to telehealth
 22 services described in the preceding sentence that are
 23 furnished on or after January 1, 2020, nothing shall
 24 preclude the furnishing of such services through
 25 audio or telephone only technologies in the case
 26 where a physician or practitioner has already con-

ducted an in-person medical evaluation or a telehealth evaluation that utilizes both audio and visual capabilities with the eligible telehealth individual.”.

(2) CONTROLLED SUBSTANCES DISPENSED BY MEANS OF THE INTERNET.—Section 309(e)(2) of the Controlled Substances Act (21 U.S.C. 829(e)(2)) is amended—

(A) in subparagraph (A)(i)—

(i) by striking “at least 1 in-person medical evaluation” and inserting the following: “at least—

“(I) 1 in-person medical evaluation”; and

(ii) by adding at the end the following:

“(II) for purposes of prescribing a controlled substance in schedule III or IV, 1 telehealth evaluation; or”; and

(B) by adding at the end the following:

“(D)(i) The term ‘telehealth evaluation’ means a medical evaluation that is conducted in accordance with applicable Federal and State laws by a practitioner (other than a pharmacist) who is at a location remote from the

1 patient and is communicating with the patient
2 using a telecommunications system referred to
3 in section 1834(m) of the Social Security Act
4 (42 U.S.C. 1395m(m)) that includes, at a min-
5 imum, audio and video equipment permitting
6 two-way, real-time interactive communication
7 between the patient and distant site practi-
8 tioner.

9 “(ii) Nothing in clause (i) shall be con-
10 strued to imply that 1 telehealth evaluation
11 demonstrates that a prescription has been
12 issued for a legitimate medical purpose within
13 the usual course of professional practice.

14 “(iii) A practitioner who prescribes the
15 drugs or combination of drugs that are covered
16 under section 303(g)(2)(C) using the authority
17 under subparagraph (A)(i)(II) of this para-
18 graph shall adhere to nationally recognized evi-
19 dence-based guidelines for the treatment of pa-
20 tients with opioid use disorders and a diversion
21 control plan, as those terms are defined in sec-
22 tion 8.2 of title 42, Code of Federal Regula-
23 tions, as in effect on the date of enactment of
24 this subparagraph.”.

1 **Subtitle B—Recovery Housing**

2 **SEC. 311. CLARIFYING THE ROLE OF SAMHSA IN PRO-**
3 **MOTING THE AVAILABILITY OF HIGH-QUAL-**
4 **ITY RECOVERY HOUSING.**

5 Section 501(d) of the Public Health Service Act (42
6 U.S.C. 290aa) is amended—

7 (1) in paragraph (24)(E), by striking “and” at
8 the end;

9 (2) in paragraph (25), by striking the period at
10 the end and inserting “; and”; and

11 (3) by adding at the end the following:

12 “(26) collaborate with national accrediting enti-
13 ties and reputable providers and analysts of recovery
14 housing services and all relevant Federal agencies,
15 including the Centers for Medicare & Medicaid Serv-
16 ices, the Health Resources and Services Administra-
17 tion, other offices and agencies within the Depart-
18 ment of Health and Human Services, the Office of
19 National Drug Control Policy, the Department of
20 Justice, the Department of Housing and Urban De-
21 velopment, and the Department of Agriculture, to
22 promote the availability of high-quality recovery
23 housing for individuals with a substance use dis-
24 order.”.

1 **SEC. 312. DEVELOPING GUIDELINES FOR STATES TO PRO-**
 2 **MOTE THE AVAILABILITY OF HIGH-QUALITY**
 3 **RECOVERY HOUSING.**

4 (a) IN GENERAL.—Not later than 1 year after the
 5 date of the enactment of this Act, the Secretary of Health
 6 and Human Services, acting through the Assistant Sec-
 7 retary for Mental Health and Substance Use, shall de-
 8 velop, and publish on the Internet website of the Sub-
 9 stance Abuse and Mental Health Services Administration,
 10 consensus-based guidelines and nationally recognized
 11 standards for States to promote the availability of high-
 12 quality recovery housing for individuals with a substance
 13 use disorder. Such guidelines shall—

14 (1) be developed in consultation with national
 15 accrediting entities and reputable providers and ana-
 16 lysts of recovery housing services and be consistent
 17 with the best practices developed under section 550
 18 of the Public Health Service Act (42 U.S.C. 290ee–
 19 5); and

20 (2) to the extent practicable, build on existing
 21 best practices and suggested guidelines developed
 22 previously by the Substance Abuse and Mental
 23 Health Services Administration.

24 (b) PUBLIC COMMENT PERIOD.—Before finalizing
 25 guidelines under subsection (a), the Secretary of Health

1 and Human Services shall provide for a public comment
2 period.

3 (c) EXCLUSION OF GUIDELINE ON TREATMENT
4 SERVICES.—In developing the guidelines under subsection
5 (a), the Secretary may not include any guideline or stand-
6 ard with respect to substance use disorder treatment serv-
7 ices.

8 (d) SUBSTANCE USE DISORDER TREATMENT SERV-
9 ICES.—In this section, the term “substance use disorder
10 treatment services” means items or services furnished for
11 the treatment of a substance use disorder, including—

12 (1) medications approved by the Food and
13 Drug Administration for use in such treatment, ex-
14 cluding each such medication used to prevent or
15 treat a drug overdose;

16 (2) the administering of such medications;

17 (3) recommendations for such treatment;

18 (4) clinical assessments and referrals;

19 (5) counseling with a physician, psychologist, or
20 mental health professional (including individual and
21 group therapy); and

22 (6) toxicology testing.

1 **SEC. 313. COORDINATION OF FEDERAL ACTIVITIES TO PRO-**
 2 **MOTE THE AVAILABILITY OF HIGH-QUALITY**
 3 **RECOVERY HOUSING.**

4 Section 550 of the Public Health Service Act (42
 5 U.S.C. 290ee–5) is amended—

6 (1) by redesignating subsections (e), (f), and
 7 (g) as subsections (h), (i), and (j), respectively; and

8 (2) by inserting after subsection (d) the fol-
 9 lowing:

10 “(e) COORDINATION OF FEDERAL ACTIVITIES TO
 11 PROMOTE THE AVAILABILITY OF HIGH-QUALITY RECOV-
 12 ERY HOUSING FOR INDIVIDUALS WITH A SUBSTANCE
 13 USE DISORDER.—

14 “(1) IN GENERAL.—The Secretary, acting
 15 through the Assistant Secretary, and the Secretary
 16 of the Department of Housing and Urban Develop-
 17 ment, shall convene and serve as the co-chairs of an
 18 interagency working group composed of representa-
 19 tives of each of the Federal agencies described in
 20 paragraph (2) (referred to in this section as the
 21 ‘working group’) for the following purposes:

22 “(A) To increase collaboration, coopera-
 23 tion, and consultation among such Federal
 24 agencies, with respect to promoting the avail-
 25 ability of high-quality recovery housing.

1 “(B) To align the efforts of such agencies
2 and avoid duplication of such efforts by such
3 agencies.

4 “(C) To develop objectives, priorities, and
5 a long- term plan for supporting State, Tribal,
6 and local efforts with respect to the operation
7 of high-quality recovery housing that is con-
8 sistent with the best practices developed under
9 this section.

10 “(D) To coordinate inspection and enforce-
11 ment among Federal and State agencies.

12 “(E) To coordinate data collection on the
13 quality of recovery housing.

14 “(2) FEDERAL AGENCIES DESCRIBED.—The
15 Federal agencies described in this paragraph are the
16 following:

17 “(A) The Department of Health and
18 Human Services.

19 “(B) The Centers for Medicare & Medicaid
20 Services.

21 “(C) The Substance Abuse and Mental
22 Health Services Administration.

23 “(D) The Health Resources and Services
24 Administration.

25 “(E) The Indian Health Service.

1 “(F) The Department of Housing and
2 Urban Development.

3 “(G) The Department of Agriculture.

4 “(H) The Department of Justice.

5 “(I) The Office of National Drug Control
6 Policy.

7 “(J) The Bureau of Indian Affairs.

8 “(K) Any other such agency or subagency
9 as the chair determines necessary and appro-
10 priate.

11 “(3) MEETINGS.—The working group shall
12 meet on a quarterly basis.

13 “(4) REPORTS TO CONGRESS.—Beginning not
14 later than 1 year after the date of the enactment of
15 this section and annually thereafter, the working
16 group shall submit to the Committee on Health,
17 Education, Labor, and Pensions, the Committee on
18 Agriculture, Nutrition, and Forestry, and the Com-
19 mittee on Finance of the Senate and the Committee
20 on Energy and Commerce, the Committee on Ways
21 and Means, the Committee on Agriculture, and the
22 Committee on Financial Services of the House of
23 Representatives a report describing the work of the
24 working group and any recommendations of the

1 working group to improve Federal, State, or local
 2 policy with respect to recovery housing operations.”.

3 **SEC. 314. NAS STUDY.**

4 Section 550 of the Public Health Service Act (42
 5 U.S.C. 290ee–5), as amended by section 313, is further
 6 amended by inserting after subsection (e) (as inserted by
 7 such section 313) the following:

8 “(f) NAS STUDY AND REPORT.—

9 “(1) IN GENERAL.—The Secretary, acting
 10 through the Assistant Secretary, shall enter into an
 11 arrangement with the National Academy of Sciences
 12 under which the National Academy agrees to con-
 13 duct a study on—

14 “(A) the availability in the United States
 15 of high-quality recovery housing and whether
 16 that availability meets the demand for such
 17 housing in the United States; and

18 “(B) State, Tribal, and local regulation
 19 and oversight of recovery housing.

20 “(2) REPORT.—The arrangement under para-
 21 graph (1) shall provide for the National Academy of
 22 Sciences to submit, not later than 1 year after the
 23 date of the enactment of this subsection, a report
 24 that contains—

1 “(A) the results of the study under such
2 paragraph;

3 “(B) the National Academy’s recommenda-
4 tions for Federal, State, and local policies to
5 promote the availability of high-quality recovery
6 housing in the United States;

7 “(C) recommendations for Federal, State,
8 and local policies to improve data collection on
9 the quality of recovery housing;

10 “(D) recommendations for recovery hous-
11 ing quality metrics;

12 “(E) recommendations to eliminate restric-
13 tions by recovery residences that exclude indi-
14 viduals who take prescribed medications for
15 opioid use disorder; and

16 “(F) a summary of allegations, assertions,
17 or formal legal actions on the State and local
18 levels by governments and non-governmental or-
19 ganizations with respect to the opening and op-
20 eration of recovery residences.

21 “(3) CONSULTATION.—In conducting the study
22 under this subsection, the National Academy of
23 Sciences shall consult with national accrediting enti-
24 ties and reputable providers and analysts of recovery
25 housing services.”.

1 **SEC. 315. GRANTS FOR STATES TO PROMOTE THE AVAIL-**
 2 **ABILITY OF HIGH QUALITY RECOVERY HOUS-**
 3 **ING.**

4 Section 550 of the Public Health Service Act (42
 5 U.S.C. 290ee-5), as amended by sections 313 and 314
 6 is further amended by inserting after subsection (f) (as
 7 inserted by such section 314) the following:

8 “(g) GRANTS FOR IMPLEMENTING NATIONAL RE-
 9 COVERY HOUSING BEST PRACTICES.—

10 “(1) IN GENERAL.—The Secretary shall award
 11 grants to States (and political subdivisions thereof),
 12 Tribes, and territories—

13 “(A) for the provision of technical assist-
 14 ance by national accrediting entities and rep-
 15 utable providers and analysts of recovery hous-
 16 ing services to implement the guidelines, nation-
 17 ally recognized standards, and recommendations
 18 developed under section 312 of the CARA 2.0
 19 Act of 2020 and this section; and

20 “(B) to promote the availability of high-
 21 quality recovery housing for individuals with a
 22 substance use disorder and practices to main-
 23 tain housing quality long term.

24 “(2) STATE ENFORCEMENT PLANS.—Beginning
 25 not later than 90 days after the date of the enact-
 26 ment of this paragraph and every 2 years thereafter,

1 as a condition on the receipt of a grant under para-
 2 graph (1), each State (or political subdivisions there-
 3 of), Tribe, or territory receiving such a grant shall
 4 submit to the Secretary, and make publicly available
 5 on a publicly accessible Internet website of the State
 6 (or political subdivisions thereof), Tribe, or territory,
 7 the plan of the State (or political subdivisions there-
 8 of), Tribe, or territory, with respect to the promotion
 9 of high-quality recovery housing for individuals with
 10 a substance use disorder located within the jurisdic-
 11 tion of such State (or political subdivisions thereof),
 12 Tribe, or territory, and how such plan is consistent
 13 with the best practices developed under this section
 14 and guidelines developed under section 312 of the
 15 CARA 2.0 Act of 2020.

16 “(3) REVIEW OF ACCREDITING ENTITIES.—The
 17 Secretary shall periodically review the accrediting
 18 entities providing technical assistance pursuant to
 19 paragraph (1)(A).”.

20 **SEC. 316. AUTHORIZATION OF APPROPRIATIONS.**

21 Section 550 of the Public Health Service Act (42
 22 U.S.C. 290ee–5), as amended by sections 313, 314, and
 23 315, is further amended by amending subsection (j) (as
 24 redesignated by such section 313) to read as follows:

25 “(j) AUTHORIZATION OF APPROPRIATIONS.—

1 “(1) IN GENERAL.—To carry out this section,
2 there is authorized to be appropriated—

3 “(A) \$2,000,000 for fiscal year 2021; and

4 “(B) \$11,000,000 for each of fiscal years
5 2022 through 2026.

6 “(2) RESERVATIONS OF FUNDS.—For each of
7 fiscal years 2021 through 2026, of the amounts ap-
8 propriated under paragraph (1) for such fiscal year,
9 the Secretary shall reserve—

10 “(A) not less than \$1,000,000 to carry out
11 subsection (e);

12 “(B) not less than \$1,000,000 to carry out
13 subsection (f); and

14 “(C) not less than \$10,000,000 to carry
15 out subsection (g).”.

16 **SEC. 317. REPUTABLE PROVIDERS AND ANALYSTS OF RE-**
17 **COVERY HOUSING SERVICES DEFINITION.**

18 Section 550(i) of the Public Health Service Act (42
19 U.S.C. 290ee–5(i)), as redesignated by section 313, is
20 amended by adding at the end the following:

21 “(4) The term ‘reputable providers and analysts
22 of recovery housing services’ means recovery housing
23 service providers and analysts that—

24 “(A) use evidence-based approaches;

1 “(B) act in accordance with guidelines
 2 issued by the Assistant Secretary for Mental
 3 Health and Substance Use;

4 “(C) have not been found guilty of health
 5 care fraud by the Department of Justice; and

6 “(D) have not been found to have violated
 7 Federal, State, or local codes of conduct with
 8 respect to recovery housing for individuals with
 9 a substance use disorder.”.

10 **SEC. 318. TECHNICAL CORRECTION.**

11 Title V of the Public Health Service Act (42 U.S.C.
 12 290aa et seq.) is amended—

13 (1) by redesignating section 550 (relating to
 14 Sobriety Treatment and Recovery Teams) (42
 15 U.S.C. 290ee–10), as added by section 8214 of Pub-
 16 lic Law 115–271, as section 550A; and

17 (2) moving such section so it appears after sec-
 18 tion 550 (relating to National Recovery Housing
 19 Best Practices).

20 **TITLE IV—CRIMINAL JUSTICE**

21 **SEC. 401. MEDICATION-ASSISTED TREATMENT CORREC-**
 22 **TIONS AND COMMUNITY REENTRY PROGRAM.**

23 (a) DEFINITIONS.—In this section—

1 (1) the term “Attorney General” means the At-
2 torney General, acting through the Director of the
3 National Institute of Corrections;

4 (2) the term “certified recovery coach” means
5 an individual—

6 (A) with knowledge of, or experience with,
7 recovery from a substance use disorder; and

8 (B) who—

9 (i) has completed training through,
10 and is determined to be in good standing
11 by—

12 (I) a single State agency; or

13 (II) a recovery community orga-
14 nization that is capable of conducting
15 that training and making that deter-
16 mination; and

17 (ii) meets the criteria specified by the
18 Attorney General, in consultation with the
19 Secretary of Health and Human Services,
20 for qualifying as a certified recovery coach
21 for the purposes of this Act;

22 (3) the term “correctional facility” has the
23 meaning given the term in section 901 of title I of
24 the Omnibus Crime Control and Safe Streets Act of
25 1968 (34 U.S.C. 10251);

1 (4) the term “covered grant or cooperative
2 agreement” means a grant received, or cooperative
3 agreement entered into, under the Program;

4 (5) the term “covered program” means a pro-
5 gram—

6 (A) to provide medication-assisted treat-
7 ment to individuals who have opioid use dis-
8 order and are incarcerated within the jurisdic-
9 tion of the State or unit of local government
10 carrying out the program; and

11 (B) that is developed, implemented, or ex-
12 panded through a covered grant or cooperative
13 agreement;

14 (6) the term “medication-assisted treatment”
15 means the use of any drug or combination of drugs
16 that have been approved under the Federal Food,
17 Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) or
18 section 351 of the Public Health Service Act (42
19 U.S.C. 262) for the treatment of an opioid use dis-
20 order, in combination with evidence-based counseling
21 and behavioral therapies, such as psychosocial coun-
22 seling, overseen by 1 or more social work profes-
23 sionals and 1 or more qualified clinicians, to provide
24 a comprehensive approach to the treatment of sub-
25 stance use disorders;

1 (7) the term “nonprofit organization” means an
2 organization that is described in section 501(c)(3) of
3 the Internal Revenue Code of 1986 and is exempt
4 from taxation under section 501(a) of such Code;

5 (8) the term “Panel” means the Medication-as-
6 sisted Treatment Corrections and Community Re-
7 entry Application Review Panel established under
8 subsection (f)(2);

9 (9) the term “participant” means an individual
10 who participates in a covered program;

11 (10) the term “political appointee” has the
12 meaning given the term in section 714(h) of title 38,
13 United States Code;

14 (11) the term “Program” means the Medica-
15 tion-assisted Treatment Corrections and Community
16 Reentry Program established under subsection (b);

17 (12) the term “psychosocial” means the inter-
18 relation of social factors and individual thought and
19 behavior;

20 (13) the term “recovery community organiza-
21 tion” has the meaning given the term in section 547
22 of the Public Health Service Act (42 U.S.C. 290ee–
23 2);

24 (14) the term “single State agency” means,
25 with respect to a State or unit of local government,

1 the single State agency identified by the State, or
 2 the State in which the unit of local government is
 3 located, in the plan submitted by that State under
 4 section 1932(b)(1)(A)(i) of the Public Health Serv-
 5 ice Act (42 U.S.C. 300x–32(b)(1)(A)(i));

6 (15) the term “State” means—

7 (A) each State of the United States;

8 (B) the District of Columbia; and

9 (C) each commonwealth, territory, or pos-
 10 session of the United States; and

11 (16) the term “unit of local government” has
 12 the meaning given the term in section 901 of title
 13 I of the Omnibus Crime Control and Safe Streets
 14 Act of 1968 (34 U.S.C. 10251), except that such
 15 term also includes a tribal organization, as defined
 16 in section 4 of the Indian Self-Determination and
 17 Education Assistance Act (25 U.S.C. 5304).

18 (b) AUTHORIZATION.—Not later than 90 days after
 19 the date of enactment of this Act, the Attorney General,
 20 in consultation with the Secretary of Health and Human
 21 Services, shall establish a program—

22 (1) that shall be known as the “Medication-as-
 23 sisted Treatment Corrections and Community Re-
 24 entry Program”; and

25 (2) under which the Attorney General—

1 (A) may make grants to, and enter into co-
2 operative agreements with, States or units of
3 local government to develop, implement, or ex-
4 pand 1 or more programs to provide medica-
5 tion-assisted treatment that meets the standard
6 of care generally accepted for the treatment of
7 opioid use disorder to individuals who have
8 opioid use disorder and are incarcerated within
9 the jurisdictions of the States or units of local
10 government; and

11 (B) shall establish a working relationship
12 with 1 or more knowledgeable corrections orga-
13 nizations with expertise in security, medical
14 health, mental health, and substance use dis-
15 order care to oversee and support implementa-
16 tion of the program, including through the use
17 of evidence-based clinical practices.

18 (c) USE OF FUNDS FOR INFRASTRUCTURE.—In de-
19 veloping, implementing, or expanding a medication-as-
20 sisted treatment program under subsection (b)(2)(A), a
21 State or unit of local government may use funds from a
22 grant or cooperative agreement under that subsection to
23 develop the infrastructure necessary to provide the medi-
24 cation-assisted treatment, such as—

1 (1) establishing safe storage facilities for the
2 drugs used in the treatment; and

3 (2) obtaining appropriate licenses for the indi-
4 viduals who will administer the treatment.

5 (d) PURPOSES.—The purposes of the Program are
6 to—

7 (1) develop culturally competent (as defined in
8 section 102 of the Developmental Disabilities Assist-
9 ance and Bill of Rights Act of 2000 (42 U.S.C.
10 15002)) medication-assisted treatment programs in
11 consultation with nonprofit organizations and com-
12 munity organizations that are qualified to provide
13 technical support for the programs;

14 (2) reduce the risk of overdose to participants
15 after the participants are released from incarcer-
16 ation; and

17 (3) reduce the rate of reincarceration.

18 (e) PROGRAM REQUIREMENTS.—In carrying out a
19 covered program, a State or unit of local government—

20 (1) shall ensure that each individual who is
21 newly incarcerated at a correctional facility at which
22 the covered program is carried out, and who was re-
23 ceiving medication-assisted treatment before being
24 incarcerated, continues to receive medication-assisted
25 treatment while incarcerated;

1 (2) in providing medication-assisted treatment
2 under the covered program, shall offer to partici-
3 pants each type of drug that has been approved
4 under the Federal Food, Drug, and Cosmetic Act
5 (21 U.S.C. 301 et seq.) or section 351 of the Public
6 Health Service Act (42 U.S.C. 262) for the treat-
7 ment of an opioid use disorder; and

8 (3) shall use—

9 (A) screening tools with psychometric reli-
10 ability and validity that provide useful clinical
11 data to guide the long-term treatment of par-
12 ticipants who have—

13 (i) opioid use disorder; or

14 (ii) co-occurring opioid use disorder
15 and mental disorders;

16 (B) at each correctional facility at which
17 the covered program is carried out, a sufficient
18 number of personnel, as determined by the At-
19 torney General in light of the number of indi-
20 viduals incarcerated at the correctional facility
21 and the number of those individuals whom the
22 correctional facility has screened and identified
23 as having opioid use disorder, to—

24 (i) monitor participants with active
25 opioid use disorder who begin participation

1 in the covered program while dem-
2 onstrating, or develop, signs and symptoms
3 of opioid withdrawal;

4 (ii) provide evidence-based medically
5 managed withdrawal care or assistance to
6 the participants described in clause (i);

7 (iii) prescribe or otherwise dispense—

8 (I) the drugs that are offered
9 under the covered program, as re-
10 quired under paragraph (1); and

11 (II) naloxone or any other emer-
12 gency opioid antagonist approved by
13 the Commissioner of Food and Drugs
14 to treat opioid overdose;

15 (iv) discuss with participants the risks
16 and benefits of, and differences among, the
17 opioid antagonist, opioid agonist, and par-
18 tial agonist drugs used to treat opioid use
19 disorder; and

20 (v) prepare a plan for release, includ-
21 ing connecting participants with mental
22 health and substance use treatment pro-
23 grams, medical care, public benefits, and
24 housing; and

1 (C) a certified recovery coach, social work
 2 professional, or other qualified clinician who, in
 3 order to support the sustained recovery of par-
 4 ticipants, shall work with participants who are
 5 recovering from opioid use disorder.

6 (f) APPLICATION.—

7 (1) IN GENERAL.—A State or unit of local gov-
 8 ernment desiring a covered grant or cooperative
 9 agreement shall submit to the Attorney General an
 10 application that—

11 (A) shall include—

12 (i) a description of—

13 (I) the objectives of the medica-
 14 tion-assisted treatment program that
 15 the applicant will develop, implement,
 16 or expand under the covered grant or
 17 cooperative agreement;

18 (II) the activities that the appli-
 19 cant will carry out under the covered
 20 program;

21 (III) how the activities described
 22 under subclause (II) will achieve the
 23 objectives described in subclause (I);

24 (IV) the outreach and education
 25 component of the covered program

1 that the applicant will carry out in
2 order to encourage maximum partici-
3 pation in the covered program; and

4 (V) how the applicant will de-
5 velop connections to culturally com-
6 petent (as defined in section 102 of
7 the Developmental Disabilities Assist-
8 ance and Bill of Rights Act of 2000
9 (42 U.S.C. 15002)) substance use and
10 mental health treatment providers,
11 medical professionals, nonprofit orga-
12 nizations, and other State agencies in
13 order to plan for participants to re-
14 ceive a continuum of care and appro-
15 priate wrap-around services after re-
16 lease from incarceration;

17 (ii) if, under the covered program that
18 the applicant will carry out, the applicant
19 will not, in providing medication-assisted
20 treatment, offer to participants not less
21 than 1 drug that uses an opioid antago-
22 nist, not less than 1 drug that uses an
23 opioid agonist, and not less than 1 drug
24 that uses an opioid partial agonist, an ex-
25 planation of why the applicant is unable to

1 or chooses not to offer a drug that uses an
2 opioid antagonist, a drug that uses an
3 opioid agonist, or a drug that uses an
4 opioid partial agonist, as applicable;

5 (iii) a plan for—

6 (I) measuring progress in achiev-
7 ing the objectives described in clause
8 (i)(I), including a strategy to collect
9 data that can be used to measure that
10 progress;

11 (II) collaborating with the single
12 State agency for the applicant or 1 or
13 more nonprofit organizations in the
14 community of the applicant to help
15 ensure that—

16 (aa) if participants so desire,
17 participants have continuity of
18 care after release from incarcer-
19 ation with respect to the form of
20 medication-assisted treatment the
21 participants received during in-
22 carceration, including—

23 (AA) by working with
24 community service providers
25 to assist eligible partici-

1 pants, before release from
2 incarceration in registering
3 for the Medicaid program
4 under title XIX of the Social
5 Security Act (42 U.S.C.
6 1396 et seq.) or other min-
7 imum essential coverage, as
8 defined in section 5000A(f)
9 of the Internal Revenue
10 Code of 1986; and

11 (BB) if a participant
12 cannot afford, or does not
13 qualify for, health insurance
14 that provides coverage with
15 respect to enrollment in a
16 medication-assisted treat-
17 ment program, and if the
18 participant cannot pay the
19 cost of enrolling in a medi-
20 cation-assisted treatment
21 program, by working with
22 units of local government,
23 nonprofit organizations,
24 opioid use disorder treat-
25 ment providers, and entities

1 carrying out programs under
2 substance use disorder
3 grants to, before the partici-
4 pant is released from incar-
5 ceration, identify a resource,
6 other than the applicant or
7 the covered program to be
8 carried out by the applicant,
9 that may be used to pay the
10 cost of enrolling the partici-
11 pant in a medication-as-
12 sisted treatment program;
13 (bb) medications are se-
14 curely stored; and
15 (cc) protocols relating to di-
16 version are maintained; and
17 (III) with respect to each com-
18 munity in which a correctional facility
19 at which a covered program will be
20 carried out is located, collaborating
21 with State agencies responsible for
22 overseeing programs relating to sub-
23 stance use disorder and local public
24 health officials and nonprofit organi-
25 zations in the community to help en-

1 sure that medication-assisted treat-
2 ment provided at each correctional fa-
3 cility at which the covered program
4 will be carried out is also available at
5 locations that are not correctional fa-
6 cilities in those communities, to the
7 greatest extent practicable; and

8 (iv) a certification that—

9 (I) each correctional facility at
10 which the covered program will be
11 carried out has access to a sufficient
12 number of clinicians who are licensed
13 to prescribe or otherwise dispense to
14 participants the drugs for the treat-
15 ment of opioid use disorder required
16 to be offered under subsection (e)(1),
17 which may include clinicians who use
18 telemedicine, in accordance with regu-
19 lations issued by the Administrator of
20 the Drug Enforcement Administra-
21 tion, to provide services under the cov-
22 ered program; and

23 (II) the covered program will
24 provide culturally competent (as de-
25 fined in section 102 of the Develop-

1 mental Disabilities Assistance and Bill
 2 of Rights Act of 2000 (42 U.S.C.
 3 15002)) evidence-based counseling
 4 and behavioral therapies, which may
 5 include counseling and therapy admin-
 6 istered through the use of telemedi-
 7 cine, as appropriate, to participants as
 8 part of the medication-assisted treat-
 9 ment provided under the covered pro-
 10 gram; and

11 (B) may include a statement indicating the
 12 number of participants that the applicant ex-
 13 pects to serve through the covered program.

14 (2) MEDICATION-ASSISTED TREATMENT COR-
 15 RECTIONS AND COMMUNITY REENTRY APPLICATION
 16 REVIEW PANEL.—

17 (A) IN GENERAL.—Not later than 60 days
 18 after the date of enactment of this Act, the At-
 19 torney General shall establish a Medication-as-
 20 sisted Treatment Corrections and Community
 21 Reentry Application Review Panel that shall—

22 (i) be composed of not fewer than 10
 23 individuals and not more than 15 individ-
 24 uals; and

25 (ii) include—

1 (I) 1 or more employees, who are
2 not political appointees, of—

3 (aa) the Department of Jus-
4 tice;

5 (bb) the Drug Enforcement
6 Administration;

7 (cc) the Substance Abuse
8 and Mental Health Service Ad-
9 ministration;

10 (dd) the National Center for
11 Injury Prevention and Control at
12 the Centers for Disease Control
13 and Prevention; and

14 (ee) the Office of National
15 Drug Control Policy; and

16 (II) other stakeholders who—

17 (aa) have expert knowledge
18 relating to the opioid epidemic,
19 drug treatment, health equity,
20 culturally competent (as defined
21 in section 102 of the Develop-
22 mental Disabilities Assistance
23 and Bill of Rights Act of 2000
24 (42 U.S.C. 15002)) care, or com-

1 community substance use disorder
2 services; and

3 (bb) represent law enforce-
4 ment organizations and public
5 health entities.

6 (B) DUTIES.—

7 (i) IN GENERAL.—The Panel shall—

8 (I) review and evaluate applica-
9 tions for covered grants and coopera-
10 tive agreements; and

11 (II) make recommendations to
12 the Attorney General relating to the
13 awarding of covered grants and coop-
14 erative agreements.

15 (ii) RURAL COMMUNITIES.—In review-
16 ing and evaluating applications under
17 clause (i), the Panel shall take into consid-
18 eration the unique circumstances, including
19 the lack of resources relating to the treat-
20 ment of opioid use disorder, faced by rural
21 States and units of local government.

22 (C) TERMINATION.—The Panel shall ter-
23minate on the last day of fiscal year 2023.

24 (3) PUBLICATION OF CRITERIA IN FEDERAL
25 REGISTER.—Not later than 90 days after the date of

1 enactment of this Act, the Attorney General, in con-
2 sultation with the Panel, shall publish in the Federal
3 Register—

4 (A) the process through which applications
5 submitted under paragraph (1) shall be sub-
6 mitted and evaluated; and

7 (B) the criteria used in awarding covered
8 grants and cooperative agreements.

9 (g) DURATION.—A covered grant or cooperative
10 agreement shall be for a period of not more than 4 years,
11 except that the Attorney General may extend the term of
12 a covered grant or cooperative agreement based on out-
13 come data or extenuating circumstances relating to the
14 covered program carried out under the covered grant or
15 cooperative agreement.

16 (h) REPORT.—

17 (1) IN GENERAL.—Not later than 2 years after
18 the date on which a State or unit of local govern-
19 ment is awarded a covered grant or cooperative
20 agreement, and each year thereafter until the date
21 that is 1 year after the date on which the period of
22 the covered grant or cooperative agreement ends, the
23 State or unit of local government shall submit a re-
24 port to the Attorney General that includes informa-
25 tion relating to the covered program carried out by

the State or unit of local government, including information relating to—

(A) the goals of the covered program;

(B) any evidence-based interventions carried out under the covered program;

(C) outcomes of the covered program, which shall—

(i) be reported in a manner that distinguishes the outcomes based on the categories of, with respect to the participants in the covered program—

(I) the race of the participants;

and

(II) the gender of the participants; and

(ii) include information relating to the rate of reincarceration among participants in the covered program, if available; and

(D) expenditures under the covered program.

(2) PUBLICATION.—

(A) AWARDEE.—A State or unit of local government that submits a report under paragraph (1) shall make the report publicly available on—

1 (i) the website of each correctional fa-
2 cility at which the State or unit of local
3 government carried out the covered grant
4 program; and

5 (ii) if a correctional facility at which
6 the State or unit of local government car-
7 ried out the covered grant program does
8 not operate a website, the website of the
9 State or unit of local government.

10 (B) ATTORNEY GENERAL.—The Attorney
11 General shall make each report received under
12 paragraph (1) publicly available on the website
13 of the National Institute of Corrections.

14 (3) SUBMISSION TO CONGRESS.—Not later than
15 2 years after the date on which the Attorney Gen-
16 eral awards the first covered grant or cooperative
17 agreement, and each year thereafter, the Attorney
18 General shall submit to the Committee on the Judi-
19 ciary of the Senate and the Committee on the Judi-
20 ciary of the House of Representatives a summary
21 and compilation of the reports that the Attorney
22 General has received under paragraph (1) during the
23 year preceding the date on which the Attorney Gen-
24 eral submits the summary and compilation.

1 (i) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated \$50,000,000 to carry
3 out this section for each of fiscal years 2021 through
4 2026.

5 **SEC. 402. DEFLECTION AND PRE-ARREST DIVERSION.**

6 (a) FINDINGS.—Congress finds the following:

7 (1) Law enforcement officers and other first re-
8 sponders are at the front line of the opioid epidemic.
9 However, a traditional law enforcement response to
10 substance use often fails to disrupt the cycle of ad-
11 diction and arrest, or reduce the risk of overdose.

12 (2) Law enforcement-assisted diversion and de-
13 flection programs have the potential to improve pub-
14 lic health, decrease the number of people entering
15 the criminal justice system for low-level offenses,
16 and address racial disparities.

17 (3) According to the Bureau of Justice Assist-
18 ance of the Department of Justice, “Five pathways
19 have been most commonly associated with opioid
20 overdose prevention and diversion to treatment.”
21 The 5 pathways are—

22 (A) “self-referral”, in which—

23 (i) an individual voluntarily initiates
24 contact with a first responder, such as a
25 law enforcement officer, firefighter, or

1 emergency medical services professional,
2 for a treatment referral (without fear of
3 arrest); and

4 (ii) the first responder personally in-
5 troduces the individual to a treatment pro-
6 vider (commonly known as a “warm hand-
7 off”);

8 (B) “active outreach”, in which a law en-
9 forcement officer or other first responder—

10 (i) identifies or seeks out individuals
11 in need of substance use disorder treat-
12 ment; and

13 (ii) makes a warm handoff of such an
14 individual to a treatment provider, who en-
15 gages the individual in treatment;

16 (C) “naloxone plus”, in which a law en-
17 forcement officer or other first responder en-
18 gages an individual in treatment as part of an
19 overdose response;

20 (D) “officer prevention referral”, in which
21 a law enforcement officer or other first re-
22 sponder initiates treatment engagement with an
23 individual, but no criminal charges are filed
24 against the individual; and

1 (E) “officer intervention referral”, in
2 which—

3 (i) a law enforcement officer or other
4 first responder initiates treatment engage-
5 ment with an individual; and

6 (ii)(I) criminal charges are filed
7 against the individual and held in abey-
8 ance; or

9 (II) a citation is issued to the indi-
10 vidual.

11 (4) As of the date of enactment of this Act,
12 there are no national best practices or guidelines for
13 law enforcement-assisted diversion and deflection
14 programs.

15 (b) USE OF BYRNE JAG FUNDS FOR DEFLECTION
16 AND DIVERSION PROGRAMS.—Section 501 of title I of the
17 Omnibus Crime Control and Safe Streets Act of 1968 (34
18 U.S.C. 10152) is amended—

19 (1) in subsection (a)(1)(E), by inserting before
20 the period at the end the following: “, including law
21 enforcement-assisted deflection programs and law
22 enforcement-assisted pre-arrest and pre-bookings di-
23 version programs (as those terms are defined in sub-
24 section (h))”; and

25 (2) by adding at the end the following:

1 “(h) LAW ENFORCEMENT-ASSISTED DEFLECTION
2 PROGRAMS AND LAW ENFORCEMENT-ASSISTED PRE-AR-
3 REST AND PRE-BOOKING DIVERSION PROGRAMS.—

4 “(1) DEFINITIONS.—In this subsection:

5 “(A) COVERED GRANT.—The term ‘cov-
6 ered grant’ means a grant for a deflection or di-
7 version program awarded under subsection
8 (a)(1)(E).

9 “(B) DEFLECTION OR DIVERSION PRO-
10 GRAM.—The term ‘deflection or diversion pro-
11 gram’ means a law enforcement-assisted deflec-
12 tion program or a law enforcement-assisted pre-
13 arrest or pre-booking diversion, including pro-
14 grams where—

15 “(i) an individual voluntarily initiates
16 contact with a first responder for a treat-
17 ment referral without fear of arrest and re-
18 ceives a warm handoff to treatment;

19 “(ii) a law enforcement officer or
20 other first responder identifies or seeks out
21 individuals in need of substance use treat-
22 ment and a warm handoff is made to a
23 treatment provider, who engages them in
24 treatment;

1 “(iii) a law enforcement officer or
 2 other first responder engages an individual
 3 in treatment as part of an overdose re-
 4 sponse;

5 “(iv) a law enforcement officer or
 6 other first responder initiates treatment
 7 engagement, but no criminal charges are
 8 filed;

9 “(v) a law enforcement officer or
 10 other first responder initiates treatment
 11 engagement; and/or

12 “(vi) charges are filed and held in
 13 abeyance or a citation is issued.

14 “(C) LAW ENFORCEMENT-ASSISTED DE-
 15 FLECTION PROGRAM.—The term ‘law enforce-
 16 ment-assisted deflection program’ means a pro-
 17 gram under which a law enforcement officer,
 18 when encountering an individual who is not en-
 19 gaged in criminal activity but appears to have
 20 a substance use disorder or mental health dis-
 21 order, instead of taking no action at the time
 22 of contact or taking action at a later time, at-
 23 tempts to connect the individual to substance
 24 use disorder treatment providers or mental
 25 health treatment providers—

1 “(i) without the use of coercion or
2 fear of arrest; and

3 “(ii) using established pathways for
4 connections to local, community-based
5 treatment.

6 “(D) LAW ENFORCEMENT-ASSISTED PRE-
7 ARREST OR PRE-BOOKING DIVERSION PRO-
8 GRAM.—The term ‘law enforcement-assisted
9 pre-arrest or pre-booking diversion program’
10 means a program—

11 “(i) under which a law enforcement
12 officer, when encountering an individual
13 who has committed an offense that is non-
14 violent and is not a crime against a person,
15 and the primary cause of which appears to
16 be based on a substance use disorder or
17 the mental health disorder of the indi-
18 vidual, instead of arresting the individual,
19 or instead of booking the individual after
20 having arrested the individual, attempts to
21 connect the individual to substance use dis-
22 order treatment providers or mental health
23 treatment providers—

24 “(I) without the use of coercion;
25 and

1 “(II) using established pathways
2 for connections to local, community-
3 based treatment;

4 “(ii) under which, in the case of pre-
5 arrest diversion, a law enforcement officer
6 described in clause (i) may decide to—

7 “(I) issue a civil citation; or

8 “(II) take no action with respect
9 to the offense for which the officer
10 would otherwise have arrested the in-
11 dividual described in clause (i); and

12 “(iii) that may authorize a law en-
13 forcement officer to refer an individual to
14 substance use disorder treatment providers
15 or mental health treatment providers if the
16 individual appears to have a substance use
17 disorder or mental health disorder and the
18 officer suspects the individual of chronic
19 violations of law but lacks probable cause
20 to arrest the individual (commonly known
21 as a ‘social contact referral’).

22 “(2) SENSE OF CONGRESS REGARDING DEFLEC-
23 TION OR DIVERSION PROGRAMS.—It is the sense of
24 Congress that a deflection or diversion program
25 funded under this subpart should not exclude indi-

1 viduals who are chronically exposed to the criminal
2 justice system.

3 “(3) REPORTS TO ATTORNEY GENERAL.—Not
4 later than 2 years after the date on which a State
5 or unit of local government is awarded a covered
6 grant, and each year thereafter until the date that
7 is 1 year after the date on which the period of the
8 covered grant ends, the State or unit of local govern-
9 ment shall submit a report to the Attorney General
10 that includes information relating to the deflection
11 or diversion program carried out by the State or
12 unit of local government, including information re-
13 lating to—

14 “(A) the goals of the deflection or diver-
15 sion program;

16 “(B) any evidence-based interventions car-
17 ried out under the deflection or diversion pro-
18 gram;

19 “(C) outcomes of the deflection or diver-
20 sion program, which shall—

21 “(i) be reported in a manner that dis-
22 tinguishes the outcomes based on the cat-
23 egories of, with respect to the participants
24 in the deflection or diversion program—

1 “(I) the race of the participants;

2 and

3 “(II) the gender of the partici-

4 pants; and

5 “(ii) include information relating to

6 the rate of reincarceration among partici-

7 pants in the deflection or diversion pro-

8 gram, if available; and

9 “(D) expenditures under the deflection or
10 diversion program.”.

11 (c) TECHNICAL ASSISTANCE GRANT PROGRAM.—

12 (1) DEFINITIONS.—In this subsection—

13 (A) the term “deflection or diversion pro-

14 gram” has the meaning given the term in sub-

15 section (h) of section 501 of title I of the Omni-

16 bus Crime Control and Safe Streets Act of

17 1968 (34 U.S.C. 10152), as added by sub-

18 section (b); and

19 (B) the terms “State” and “unit of local

20 government” have the meanings given those

21 terms in section 901 of title I of the Omnibus

22 Crime Control and Safe Streets Act of 1968

23 (34 U.S.C. 10251).

24 (2) GRANT AUTHORIZED.—The Attorney Gen-

25 eral shall award a single grant to an entity with sig-

1 nificant experience in working with law enforcement
2 agencies, community-based treatment providers, and
3 other community-based human service providers to
4 develop or administer both diversion and deflection
5 programs, to promote and maximize the effectiveness
6 and racial equity of deflection or diversion programs,
7 in order to—

8 (A) help State and units of local govern-
9 ment launch and expand deflection or diversion
10 programs;

11 (B) develop best practices for deflection or
12 diversion teams, which shall include—

13 (i) recommendations on community
14 input and engagement in order to imple-
15 ment deflection or diversion programs as
16 rapidly as possible and with regard to the
17 particular needs of a community, including
18 regular community meetings and other
19 mechanisms for engagement with—

20 (I) law enforcement agencies;

21 (II) community-based treatment
22 providers and other community-based
23 human service providers;

24 (III) the recovery community;
25 and

1 (IV) the community at-large; and

2 (ii) the implementation of metrics to
 3 measure community satisfaction con-
 4 cerning the meaningful participation and
 5 interaction of the community with the de-
 6 flection or diversion program and program
 7 stakeholders;

8 (C) develop and publish a training and
 9 technical assistance tool kit for deflection or di-
 10 version for public education purposes;

11 (D) disseminate uniform criteria and
 12 standards for the delivery of deflection or diver-
 13 sion program services; and

14 (E) develop outcome measures that can be
 15 used to continuously inform and improve social,
 16 clinical, financial and racial equity outcomes.

17 (3) TERM.—The term of the grant awarded
 18 under paragraph (2) shall be 5 years.

19 (4) AUTHORIZATION OF APPROPRIATIONS.—
 20 There are authorized to be appropriated to the At-
 21 torney General \$30,000,000 for the grant under
 22 paragraph (2).

23 **SEC. 403. HOUSING.**

24 Section 576 of the Quality Housing and Work Re-
 25 sponsibility Act of 1998 (42 U.S.C. 13661 et seq.) is

1 amended by striking subsections (a), (b), and (c) and in-
2 serting the following:

3 “(a) INELIGIBILITY OF ILLEGAL DRUG USERS AND
4 ALCOHOL ABUSERS.—Notwithstanding any other provi-
5 sion of law, a public housing agency or an owner of feder-
6 ally assisted housing, as determined by the Secretary, may
7 only prohibit admission to the program or admission to
8 federally assisted housing for an individual whom the pub-
9 lic housing agency or owner determines is illegally using
10 a controlled substance or abusing alcohol if the agency or
11 owner determines that the individual is using the con-
12 trolled substance or abusing alcohol in a manner that
13 interferes with the health or safety of other residents.

14 “(b) AUTHORITY TO DENY ADMISSION TO CRIMINAL
15 OFFENDERS.—

16 “(1) IN GENERAL.—Except as provided in sub-
17 section (a), in addition to any other authority to
18 screen applicants, and subject to paragraphs (2) and
19 (3) of this subsection, a public housing agency or an
20 owner of federally assisted housing may only pro-
21 hibit admission to the program or to federally as-
22 sisted housing for an individual based on criminal
23 activity of the individual if the public housing agency
24 or owner determines that the individual, during a
25 reasonable time preceding the date on which the in-

1 dividual would otherwise be selected for admission,
 2 was convicted of a crime involving conduct that
 3 threatens the health or safety of other residents.

4 “(2) EXCEPTIONS AND LIMITATIONS.—A con-
 5 viction that has been vacated, a conviction the
 6 record of which has been sealed or expunged, or a
 7 conviction for a crime committed by an individual
 8 when the individual was less than 18 years of age,
 9 shall not be grounds for denial of admission under
 10 paragraph (1).

11 “(3) ADMISSION POLICY.—

12 “(A) FACTORS TO CONSIDER.—In evalu-
 13 ating the criminal history of an individual
 14 under paragraph (1), a public housing agency
 15 or an owner of federally assisted housing shall
 16 consider—

17 “(i) whether an offense of which the
 18 individual was convicted bears a relation-
 19 ship to the safety and security of other
 20 residents;

21 “(ii) the level of violence, if any, of an
 22 offense of which the individual was con-
 23 victed;

24 “(iii) the length of time since a con-
 25 viction;

1 “(iv) the number of convictions;

2 “(v) if the individual is in recovery for
3 a substance use disorder, whether the indi-
4 vidual was under the influence of alcohol
5 or illegal drugs at the time of an offense;
6 and

7 “(vi) any rehabilitation efforts that
8 the individual has undertaken since the
9 time of a conviction, including completion
10 of a substance use treatment program.

11 “(B) WRITTEN POLICY.—A public housing
12 agency or an owner of federally assisted hous-
13 ing shall establish and make available to appli-
14 cants a written admission policy that enumer-
15 ates the specific factors, including the factors
16 described in subparagraph (A), that will be con-
17 sidered when the public housing agency or
18 owner evaluates the criminal history of an indi-
19 vidual under paragraph (1).”.

20 **SEC. 404. VETERANS TREATMENT COURTS.**

21 Section 2991 of title I of the Omnibus Crime Control
22 and Safe Streets Act of 1968 (34 U.S.C. 10651) is amend-
23 ed—

24 (1) in subsection (a)—

25 (A) in paragraph (2)—

(i) in the matter preceding subparagraph (A)—

(I) by inserting “, substance use disorder,” after “mental health”; and

(II) by inserting “or adults or juveniles with substance use disorders” after “mentally ill adults or juveniles”;

(ii) in subparagraph (A), by inserting “or substance use” after “mental health”; and

(iii) in subparagraph (B), by inserting “or substance use” after “mental health”; (B) in paragraph (4)—

(i) in subparagraph (A), by inserting “or substance use disorder” after “mental health”; and

(ii) in subparagraph (C), by inserting “or offenders with substance use disorders” after “mentally ill offenders”; (C) in paragraph (5)—

(i) in the heading, by inserting “OR SUBSTANCE USE DISORDER” after “MENTAL HEALTH”;

1 (ii) by striking “mental health agen-
 2 cy” and inserting “mental health or sub-
 3 stance use agency”; and

4 (iii) by inserting “, substance use
 5 services,” after “mental health services”;

6 (D) in paragraph (9)—

7 (i) in subparagraph (A)—

8 (I) in clause (i)—

9 (aa) in subclause (I), by in-
 10 serting “, a substance use dis-
 11 order,” after “a mental illness”;
 12 and

13 (bb) in subclause (II), by in-
 14 serting “, substance use dis-
 15 order,” after “mental illness”;
 16 and

17 (II) in clause (ii)(II), by inserting
 18 “or substance use” after “mental
 19 health”;

20 (E) by redesignating paragraph (11) as
 21 paragraph (12); and

22 (F) by inserting after paragraph (10) the
 23 following:

1 “(11) SUBSTANCE USE COURT.—The term ‘sub-
2 stance use court’ means a judicial program that
3 meets the requirements of part EE of this title.”;

4 (2) in subsection (b)—

5 (A) in paragraph (2)—

6 (i) in subparagraph (A), by inserting
7 “, substance use courts,” after “mental
8 health courts”;

9 (ii) in subparagraph (B)—

10 (I) by inserting “mental health
11 disorders, substance use disorders, or”
12 before “co-occurring mental illness
13 and substance use problems”; and

14 (II) by striking “illnesses” and
15 inserting “disorders, illnesses, or
16 problems”;

17 (iii) in subparagraph (C)—

18 (I) in the matter preceding clause

19 (i)—

20 (aa) by striking “mental
21 health agencies” and inserting
22 “mental health or substance use
23 agencies”; and

1 (bb) by striking “and, where
 2 appropriate,” and inserting “or”;
 3 and

4 (II) in clause (i), by inserting “,
 5 substance use disorders,” after “men-
 6 tal illness”; and

7 (iv) in subparagraph (D), by inserting
 8 “or offender with a substance use dis-
 9 order” after “mentally ill offender”; and
 10 (B) in paragraph (5)—

11 (i) in subparagraph (B)—

12 (I) in clause (i)—

13 (aa) by inserting “or sub-
 14 stance use court” after “mental
 15 health court”; and

16 (bb) by striking “mental
 17 health agency” and inserting
 18 “mental health or substance use
 19 agency”; and

20 (II) in clause (ii), by striking
 21 “and substance use services for indi-
 22 viduals with co-occurring mental
 23 health and substance use disorders”
 24 and inserting “or substance use serv-
 25 ices”;

1 (ii) in subparagraph (C)—

2 (I) in clause (i)(I), by inserting
3 “, substance use disorders,” after
4 “mental illness”;

5 (II) in clause (ii)—

6 (aa) in subclause (II), by in-
7 serting “, substance use,” after
8 “mental health,”;

9 (bb) in subclause (V), by
10 striking “mental health services”
11 and inserting “mental health or
12 substance use services”; and

13 (cc) in subclause (VI), by in-
14 serting “or individuals with sub-
15 stance use disorders” after “men-
16 tally ill individuals”;

17 (iii) in subparagraph (D), by inserting
18 “or offenders with substance use dis-
19 orders” after “mentally ill offenders”;

20 (iv) in subparagraph (E), by inserting
21 “or substance use disorders” after “mental
22 illness”;

23 (v) in subparagraph (H), by striking
24 “and mental health” and inserting “, men-
25 tal health, and substance use”; and

1 (vi) in subparagraph (I)—

2 (I) in clause (i)—

3 (aa) in the heading, by in-
 4 serting “, SUBSTANCE USE
 5 COURTS,” after “MENTAL
 6 HEALTH COURTS”;

7 (bb) by inserting “or sub-
 8 stance use courts” after “mental
 9 health courts”; and

10 (cc) by inserting “or part
 11 EE, as applicable,” after “part
 12 V”; and

13 (II) in clause (iv), by inserting
 14 “or substance use” after “mental
 15 health”;

16 (3) in subsection (c)—

17 (A) in paragraph (1), by inserting “, of-
 18 fenders with substance use disorders,” after
 19 “mentally ill offenders”;

20 (B) in paragraph (2), by inserting “ and
 21 offenders with substance use disorders” after
 22 “mentally ill offenders”; and

23 (C) in paragraph (3), by inserting “or sub-
 24 stance use courts” after “mental health
 25 courts”;

1 (4) in subsection (e)—

2 (A) in paragraph (1), by inserting “or sub-
3 stance use disorders” after “mental illness”;
4 and

5 (B) in paragraph (4), by inserting “or sub-
6 stance use disorders” after “mental illness”;

7 (5) in subsection (h)—

8 (A) in the heading, by inserting “AND OF-
9 FENDERS WITH SUBSTANCE USE DISORDERS”
10 after “MENTALLY ILL OFFENDERS”;

11 (B) in paragraph (1)—

12 (i) in subparagraph (A), by inserting
13 “or substance use disorders” after “mental
14 illnesses”;

15 (ii) in subparagraph (C), by inserting
16 “or offenders with substance use dis-
17 orders” after “mentally ill offenders”;

18 (iii) in subparagraph (D)—

19 (I) by inserting “or substance
20 use” after “mental health”; and

21 (II) by inserting “or offenders
22 with substance use disorders” after
23 “mentally ill offenders”;

1 (iv) in subparagraph (E), by inserting
 2 “or substance use disorders” after “mental
 3 illnesses”; and

4 (v) in subparagraph (F), by inserting
 5 “, substance use disorders,” after “mental
 6 health disorders”; and

7 (C) in paragraph (2), by inserting “or sub-
 8 stance use disorders” after “mental illnesses”;
 9 (6) in subsection (i)(2)—

10 (A) in subparagraph (B)—

11 (i) by redesignating clauses (i), (ii),
 12 and (iii) as subclauses (I), (II), and (III),
 13 and adjusting the margins accordingly;

14 (ii) in the matter preceding subclause
 15 (I), as so redesignated, by striking “shall
 16 give priority to applications that—” and
 17 inserting the following: “shall give priority
 18 to—

19 “(i) applications that—”; and

20 (iii) by striking the period at the end
 21 and inserting the following: “; and

22 “(ii) applications to establish or ex-
 23 pand veterans treatment court programs
 24 that—

1 “(I) allow participation by a vet-
 2 eran receiving any type of medication-
 3 assisted treatment that involves the
 4 use of any drug or combination of
 5 drugs that have been approved under
 6 the Federal Food, Drug, and Cos-
 7 metic Act (21 U.S.C. 301 et seq.) or
 8 section 351 of the Public Health Serv-
 9 ice Act (42 U.S.C. 262) for the treat-
 10 ment of an opioid use disorder;

11 “(II) follow the Adult Drug
 12 Court Best Practice Standards pub-
 13 lished by the National Association of
 14 Drug Court Professionals; and

15 “(III) provide culturally com-
 16 petent (as defined in section 102 of
 17 the Developmental Disabilities Assist-
 18 ance and Bill of Rights Act of 2000
 19 (42 U.S.C. 15002)) services.”; and

20 (B) by adding at the end the following:

21 “(C) DISCLOSURE AND REPORTING RE-
 22 QUIREMENTS.—

23 “(i) REQUIREMENTS FOR VETERANS
 24 TREATMENT COURT PROGRAM GRANT-
 25 EES.—An applicant that receives a grant

1 under this subsection to establish or ex-
2 pand a veterans treatment court program
3 shall—

4 “(I) disclose to the Attorney
5 General any contract or relationship
6 between the applicant and a local
7 treatment provider;

8 “(II) track and report to the At-
9 torney General the number of refer-
10 rals to local treatment providers pro-
11 vided by the program; and

12 “(III) track and report to the At-
13 torney General, with respect to each
14 participant in the program—

15 “(aa) each charge brought
16 against the participant;

17 “(bb) the demographics of
18 the participant; and

19 “(cc) the outcome of the
20 participant’s case.

21 “(ii) ATTORNEY GENERAL REPORT.—
22 The Attorney General shall periodically
23 submit to Congress a report containing the
24 information reported to the Attorney Gen-
25 eral under clause (i).

1 “(D) SENSE OF CONGRESS REGARDING
2 VETERANS TREATMENT COURT PROGRAMS.—It
3 is the sense of Congress that a veterans treat-
4 ment court program that receives funding from
5 a grant under this subsection should not ex-
6 clude individuals who are chronically exposed to
7 the criminal justice system.”;

8 (7) in subsection (j)—

9 (A) in paragraph (1), by inserting “or sub-
10 stance use disorders” after “mental illness”;
11 and

12 (B) in paragraph (2)(A), by inserting “or
13 substance use disorders” after “mental ill-
14 nesses”;

15 (8) in subsection (k)(3)(A)(i)(I)(aa), by insert-
16 ing “ or substance use disorders” after “mental ill-
17 nesses”;

18 (9) in subsection (l)—

19 (A) in paragraph (1)(B)(ii), by inserting
20 “or substance use disorder” after “mental ill-
21 ness” each place that term appears; and

22 (B) in paragraph (2)—

23 (i) in subparagraph (C)(iii), by insert-
24 ing “or substance use” after “mental
25 health”; and

1 (ii) in subparagraph (D), by striking
 2 “mental health or” and inserting “mental
 3 health disorders, substance use disorders,
 4 or”; and

5 (10) in subsection (o)(3)—

6 (A) by striking “LIMITATION” and insert-
 7 ing “VETERANS”;

8 (B) by striking “Not more than” and in-
 9 serting the following:

10 “(A) LIMITATION.—Not more than”;

11 (C) in subparagraph (A), as so designated,
 12 by striking “this section” and inserting “para-
 13 graph (1)”; and

14 (D) by adding at the end the following:

15 “(B) ADDITIONAL FUNDING.—In addition
 16 to the amounts authorized under paragraph (1),
 17 there are authorized to be appropriated to the
 18 Department of Justice to carry out subsection
 19 (i) \$20,000,000 for each of fiscal years 2021
 20 through 2026.”.

○